Name: Collin Raye Million | DOB: 8/12/1994 | MRN: CEUE02790435 | PCP: NONE GIVEN PCP | Legal Name: Collin Raye Million

# Note From Your Admission on 04/29/23

## H&P by Jay Albert Johannigman at 4/29/2023 11:34 PM

centura St. Anthony Hospital
Trauma & Acute Care Surgery

**Centura St. Anthony Hospital Trauma & Acute Care Surgery**

11750 W. 2nd Place, Suite 360

Lakewood, CO 80228

P: 720-473-7120

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Patient Name: Collin Raye Million
Date of Birth: 8/12/1994
Medical Record #: CEUE02790435
Date of Admission: 4/29/2023

**ACTIVATION**

Trauma level: Full Trauma Activation
Mode of arrival: Ambulance
Transfer from: Scene
Trauma APP arrival time: 2250
Trauma attending Dr Jay Johannigman arrival time: Prior to patient arrival

**HPI and ED COURSE**

Collin Raye Million is a 28 y.o. male who presents to SAH via EMS s/p MCC. Patient was found in a parking lot approximately 30 feet away from his motorcycle. Helmeted, protective gear on. Further history unable to be obtained given patient's AMS.

ED Course:
On arrival to the ED, the patient was altered. GCS 7. Airway intact, CTAB, but decision to intubate due to AMS. Patient tachycardic but normotensive. FAST negative. RSI completed by ED physician with ketamine and paralytic. CXR confirmed placement, ETT advanced 2 cm. LLE mottled, unable to palpate PT or DP pulses, no dopplerable signals. Pelvis unstable with concern for L femur anterior dislocation, confirmed on PXR. Reduced by ED physician. Dopplerable PT signal, still no dopplerable DP signal. Blood at the meatus, RUG performed at bedside without concern for urethral injury. Foley placed by trauma physician without difficulty, urine clear yellow. Patient started on propofol for sedation. Patient remained tachycardic but normotensive. Transported to CT.

**ROS**

ROS limited secondary to severity of patient's illness

**PRIMARY SURVEY**

Airway: clear

Breathing: CTAB

Circulation: 2+ radial pulses, 2+ DP pulses on RLE, unable to palpate DP or PT pulse on LLE, LLE mottled, return of PT dopplerable signal after reduction of L femur

Disability: GCS: 7

Exposure: All clothes removed, warm blankets and Bair hugger applied

**ADJUNCTS**

1) **CXR**
- I personally reviewed the CXR in the trauma room. Findings include: ETT in high position, advanced 2cm, no PTX, no effusion, no obvious injuries

2) **Pelvic XR**
- I personally reviewed the pelvic XR in the trauma room. Findings include: comminuted L pubic rami fractures, L femur anterior dislocation, in better position after reduction

3) **FAST Exam**
**FAST Performed by Sendy Ha, MD**
Limited abdominal ultrasound (76705)
Limited cardiac ultrasound (93308)

The right upper quadrant / right lower lateral chest was assessed using a transducer probe positioned in the right flank region with sweeping anatomic visualization of the costophrenic angle, lateral diaphragm, right lateral aspect of the liver, and right kidney. There **IS NOT** appreciable anechoic or hypoechoic fluid within the right chest or right upper quadrant of the abdomen. Overall quality of the views are determined to be good.

The left upper quadrant / left lateral chest was assessed using a transducer probe positioned in the left flank region with sweeping anatomic visualization of the costophrenic angle, left lateral diaphragm, spleen, and left kidney. There **IS NOT** appreciable anechoic or hypoechoic fluid within the left chest or left upper quadrant of the abdomen. Overall quality of the views are determined to be good .

The suprapubic views of the pelvis were visualized with the transducer probe in the coronal and sagittal planes. There **IS NOT** appreciable anechoic or hypoechoic fluid was identified within the pelvis. Overall quality of the views are determined to be good .

The precordial views of the lower pericardium was visualized with the US probe placed in a subxiphoid location. There **IS NOT** obvious significant pericardial fluid was identified. Overall quality of the views are determined to be good . Technical limitations limited visualization to only the most caudal portion of the pericardium.

**Findings:**
Cardiac Window: Negative
Hepato-renal space: Negative
Subphrenic and/or spleno-renal space: Negative
Suprapubic space: Negative

**All images were reviewed by Attending Physician**

**Images saved to the electronic record under patient MRN**

## SECONDARY SURVEY

GENERAL: Lying supine
HEENT: Normocephalic, PERRL, L periorbital ecchmosis but without crepitus or edema, conjunctiva and cornea without injection, moist mucous membranes
NECK: no cervical spine stepoffs, c collar placed
BACK: no spinal stepoffs, atraumatic
CHEST: no deformity or crepitus
PULM: Respirations unlabored, no work of breathing
CV: Tachycardic, regular rhythm, 2+ symmetrical radial pulses bilaterally, 2+ R DP pulse, no dopplerable DP or PT signal on LLE
GI: Soft, non-distended, no guarding, no rigidity, no peritonitis
MSK: Localized to pain, L femur displaced anterior, pelvis unstable
DERM: Skin warm and dry, scattered abrasions throughout extremities, L knee with superficial lacerations, R shin with laceration without underlying bony instability
NEURO: GCS 4, E1V1M5
PSYCH: Unable to assess 2/2 AMS

### Past Medical History

Unable to obtain social history secondary to severity of patient's illness

### Past Surgical History

Unable to obtain past surgical history secondary to severity of patient's illness

### Medications

Unable to obtain home medications secondary to severity of patient's illness

### Allergies

Unable to obtain allergies secondary to severity of patient's illness

### Social History

Unable to obtain social history secondary to severity of patient's illness

### Family History

Unable to obtain family history secondary to severity of patient's illness

## IMAGING

XR Chest 1 View AP Portable

Result Date: 4/29/2023
Clear lungs. The endotracheal tube terminates at the level of the thoracic inlets approximately 7 cm above the carinal bifurcation. Thank you for this referral. This examination was interpreted by a Colorado Imaging Associates radiologist. Providers with questions may reach a radiologist directly at 303-223-4448. WS: LFIELDING-HOME- DICTATED BY: MIKETIC-FIELDING, LINDA Date: 04/29/2023 23:48 MT TRANSCRIBED DATE: 04/29/2023 23:48 MT

## LABS

**WBC White Blood Count**

| Date | Value | Ref Range | Status |
|---|---|---|---|
| 04/29/2023 | 8.5 | 3.7 - 11.8 10*3/µL | Final |

**HGB Hemoglobin**

| Date | Value | Ref Range | Status |
|---|---|---|---|
| 04/29/2023 | 14.3 | 11.9 - 18.0 g/dL | Final |

**HGB Hemoglobin (POC)**

| Date | Value | Ref Range | Status |
|---|---|---|---|
| 04/29/2023 | 13.6 | 11.9 - 17.4 g/dL | Final |

**HCT Hematocrit (POC)**

| Date | Value | Ref Range | Status |
|---|---|---|---|
| 04/29/2023 | 40.0 | 37.0 - 50.3 % | Final |

**HCT Hematocrit**

| Date | Value | Ref Range | Status |
|---|---|---|---|
| 04/29/2023 | 41.0 | 37.0 - 53.0 % | Final |

**MCV Mean Cell Volume**

| Date | Value | Ref Range | Status |
|---|---|---|---|
| 04/29/2023 | 91 | fL | Final |

**PLT Platelet Count**

| Date | Value | Ref Range | Status |
|---|---|---|---|
| 04/29/2023 | 203 | 150 - 400 10*3/µL | Final |

**Creatinine (POC)**

| Date | Value | Ref Range | Status |
|---|---|---|---|
| 04/29/2023 | 0.93 | 0.53 - 1.36 mg/dL | Final |

**BUN Urea Nitrogen (POC)**

| Date | Value | Ref Range | Status |
|---|---|---|---|
| 04/29/2023 | 13 | 6 - 24 mg/dL | Final |

**Sodium (POC)**

| Date | Value | Ref Range | Status |
|---|---|---|---|
| 04/29/2023 | 141 | 136 - 145 mmol/L | Final |

**Potassium (POC)**

| Date | Value | Ref Range | Status |
|---|---|---|---|
| 04/29/2023 | 3.5 | 3.5 - 5.1 mmol/L | Final |

**Chloride, (POC)**

| Date | Value | Ref Range | Status |
|---|---|---|---|
| 04/29/2023 | 103 | 96 - 111 mmol/L | Final |

No results found for: INR, PROTIME

## CONSULTS

- Orthopedics, for L femur dislocation, pelvic fractures

## ASSESSMENT AND PLAN

Collin Raye Million is a 28 y.o. male who presents to SAH s/p MCC

Primary Diagnosis(es)
1 Pelvic fractures with hematoma
2 L femur anterior dislocation
3 Altered mental status

NEURO
**Acute pain management**
- Scheduled Tylenol, Robaxin, Gabapentin
- PRN Oxycodone, Dilaudid

**Sedation**
- propofol and fentanyl. Titrate to return of neurologic exam; Spontaneous awakening trial this evening and again in am

SPINE
- CT scans of cervical, thoracic and lumbar spine cleared radiographically

CV
MAP Goal >65

RESP
- convert to SIMV mode and begin wean to spontaneous pressure support to wean to SBT in am

GI
- no acute issues

GU
Blood at meatus with normal RUQ and Foley placed uneventfully with no hematuria. Bladder displaced to right by Space of Retzius hematoma

HEME
- monitor Hgb with pelvic fracture

ID
- no anbx

MSK
- appreciate ortho input for Left acetabular fracture. Into skeletal traction for Left tonight

ENDO
- no acute issus

GOC: No Order
DRIPS: none
NUTRITION: begin in am

LINES/TUBES: peripheral(s)
GI PPX: Protonix
VTE PPX: Lovenox 40mg BID
DISPO: ICU for neurologic monitoring and hemodynamic resuscitation

The patient was evaluated and plan of care was discussed with attending surgeon Dr. Johannigman.

**Sendy Ha, MD PGY2**
**General Surgery Resident**
**720-880-0051**

## Trauma Attending Attestation for Trauma admission history and physical exam

As the attending trauma surgeon on-call and present for the evaluation and management of this

level 1 trauma activation. Present at the time of the arrival this patient with the assembled emergency medicine and trauma surgery teams. I have reviewed the contents of this history and physical as detailed above and agree with its content. I directed resuscitation efforts in the evaluation and comprehensive plan development for this patient.

**Present in the trauma bay and assembled with the trauma and emergency medicine teams for the evaluation of this patient transported by West Metro fire department. EMS report is of a motorcyclist with helmet and protective jacket who was in a collision with a vehicle resulting in separation of the motorcyclist from his bike by some 30 feet where he was found in a parking lot.**

**He was described as unresponsive at the scene he was transported with his helmet in place which was removed shortly after arriving here.**

**Primary survey showed his blood pressure to be approximately 1 30-1 40 systolic he was breathing spontaneously with adequate saturations of 93%. Glasgow Coma Scale done by Dr. Bosch was a 7. (V-1`/E-1/M-5).**

**IV lines were established and the patient appeared to be hemodynamically stable enough to tolerate endotracheal intubation. Controlled endotracheal intubation was accomplished by Dr. Bosch.**

**There was an anterior deformity of the left groin crease consistent with an anterior dislocation of the femoral head. His pulses were diminished and his leg was slightly mottled on the left. An AP pelvis film confirmed the same diagnosis and the hip was relocated with internal rotation and traction. This restored pulses to the left lower extremity.**

**A fast examination was completed by myself and was unremarkable a plain chest x-ray was normal and without significant pneumothorax.**

**Blood was noted at the penile meatus and a retrograde urethrogram was completed which was unremarkable. A Foley catheter was uneventfully placed.**

**Initial stat labs showed a base deficit of 0 and a lactate modestly elevated at 3.1 venous a 3.8 arterial. Temperature was normal. Coagulation laboratories were normal. Under my direct supervision the patient was moved to the CT scanner where he underwent CT scan of the head demonstrating small frontal lobe intraparenchymal hemorrhages on both the left and right sides. He also had a small amount of hemorrhage in the fourth ventricle. Cervical spine imaging was normal CTA of the neck was normal.**
**CT scan of the chest was remarkable for very small anterior pulmonary contusion. CT scan of the abdomen demonstrated intact liver and spleen. He had a significant medial wall disruption of his left acetabulum with a moderate preperitoneal hematoma on the inner border of the pelvis within the space of Retzius. Ladder was displaced to the right. It was otherwise unremarkable.**

**The patient was removed for admission to the surgical ICU the trauma team accompanied the patient to the unit and gave report to the nursing and ICU staff. He is hemodynamically normalizing. We will continue to monitor his acid-base status. We will try to wean the propofol and fentanyl to gain a neurologic exam. We will convert him to a spontaneous breathing mode and wean the ventilator as appropriate. Neurosurgery consultation will be obtained.**

Patient qualifies is critically ill based upon the level 1 activation criteria and the total time spent

managing this critically ill patient was 95 minutes.

Have been present and constant supervision through the entirety of this evaluation.

Jay Johannigman MD FACS
TMD St. Anthony's hospital

**Trauma Phone: 720-880-0106**
**General Surgery Phone: 720-880-0162**
**Surgical ICU phone: 720-880-0051**